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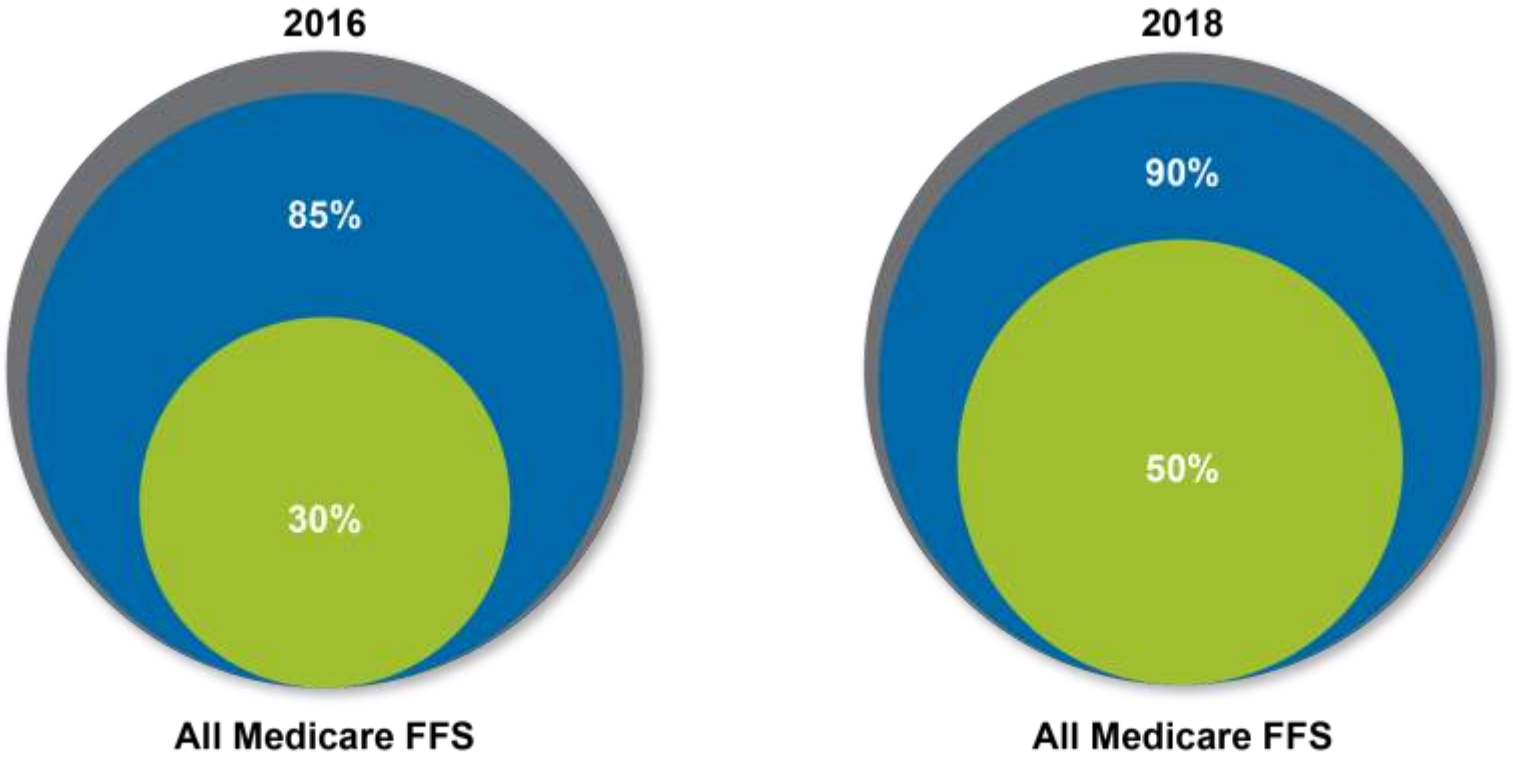
Affordable, Quality, Patient-Centered Care: An Overview of Payment Reform and National Movement to Value Based Payment

Sandeep Wadhwa, MD

Medicare Payment Targets



Fact Sheets: Better Care, Smarter Spending, Healthier People: Paying Providers for Value , Not Volume, CMS, 1/25/2015.

Payment Taxonomy Framework

	Category 1: Fee-for-Service	Category 2: Fee-for-Service	Category 3: Alternative Payment Models Built on Fee-for-Service Architecture	Category 4: Population-based Payment
Description	Payments are based on volume of services and not linked to quality or efficiency	At least a portion of payments vary based on the quality or efficiency of health care delivery	Some payment is linked to the effective management of a population or an episode of care. Payments are still triggered by delivery of services, but opportunities for shared savings or two-sided risk	Payment is not directly triggered by service delivery, so volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g. ≤ 1year)
Medicare FFS	• Limited in Medicare FFS • Majority of Medicare payments now are linked to quality	• Hospital value-based purchasing • Physician value-based modifier • Readmissions/ Hospital Acquired Condition Reduction Program	• Accountable care organizations • Medical homes • Bundled payments • Comprehensive primary care initiative • Comprehensive ESRD • Medicare-Medicaid Financial Alignments Initiative FFS Model	• Eligible Pioneer ACOs in year 3-5

Fact Sheets: Better Care, Smarter Spending, Healthier People: Paying Providers for Value , Not Volume, CMS, 1/2/2015.

Health Care Payment Learning and Action Network

Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume

- President Obama, Secretary Burwell, and Dr. Conway kicked off meeting on 3/25
- http://innovation.cms.gov/initiatives/Health-Care-Payment-Learning-and-Action-Network/

CMS Innovation Center

- Center for Medicare & Medicaid Innovation (CMMI)
  - Congress further provided the authority to expand through **rulemaking** the duration and scope of a model or demonstration project – including nationwide implementation – if expansion would
  - Reduce spending without reducing quality of care **OR**
  - Improve quality of care without increasing spending.

Innovation Center's Priorities

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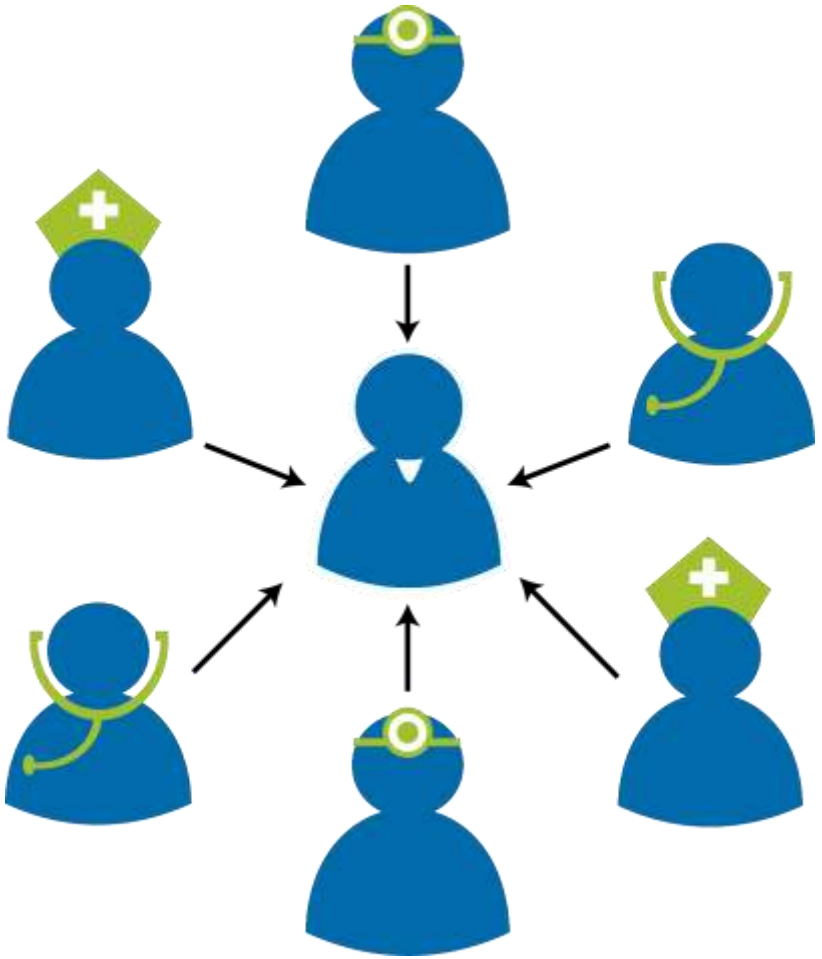
Portfolio of Models: 7 Categories

CMMI Models

1. Accountable Care Organizations (ACOs)
2. Bundled Payments for Care Improvement
3. Primary Care Transformation
4. Initiatives Focused on Medicaid and CHIP
5. Initiatives Focused on Medicare-Medicaid
6. Initiatives to Speed the Adoption of Best Practices
7. Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery

What is an ACO?

- Groups of doctors, hospitals, or other health care providers who come together voluntarily to give coordinated high quality care to Medicare patients



Three Core Principles of ACOs

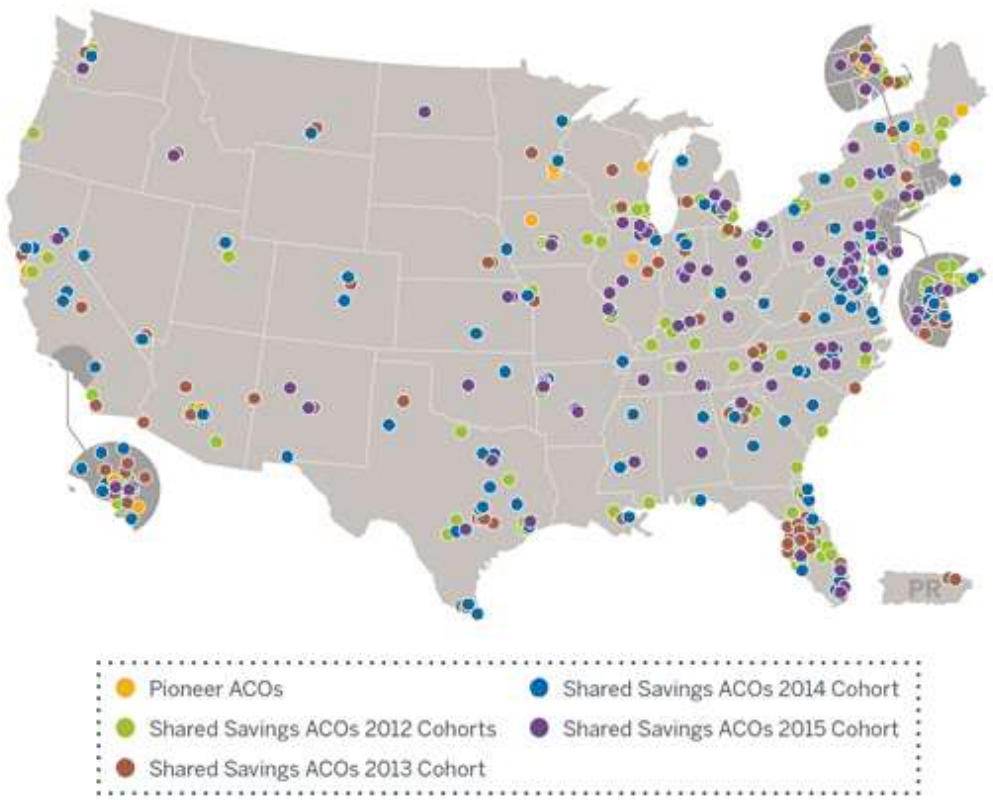
Provider-led organizations with a strong base of primary care are collectively accountable for quality and total per capita costs across full continuum of care for a population of patients

Payments linked to quality improvements reduce overall costs

Reliable and progressively more sophisticated performance measurement, to support improvement and provide confidence that savings are achieved through improvements of care

Where are the ACOs?

- 19 Pioneer and 405 Shared Savings Program ACOs as of January 2015



Where the Medicare ACOs Are, 2014 edition, The Advisory Board Company, retrieved 5/11/2015.

ACO Performance to Date

- $372 million savings for Trust Fund
  - (23 Pioneer/220 MSSP)
- Half reduced costs but only ¼ eligible for shared savings
- Pioneers achieved .45% lower spending than FFS

ACO Performance Results Demonstrate Savings to Medicare, Minimal Savings to Individual ACOs, Avalere, 9/18/14, http://avalere.com/news/aco-performance-results-demonstrate-savings-to-medicare-minimal-savings-to.

Evans, M., CMS posts long-awaited Pioneer ACO quality and financial results, Modern Healthcare, 10/8/2014, http://www.modernhealthcare.com/article/20141008/NEWS/310089921

Fact sheets: Medicare ACOs continue to succeed in improving care, lowering cost growth, CMS, 9/16/2014, http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact- sheets/2014-Fact-sheets-items/2014-09-16.html

Medicare's Pioneer ACO Program Loses Three More Participants, Healthcare Informatics, 9/25/2014, http://www.healthcare-informatics.com/article/breaking-news-medicare-s-pioneer-aco-program-loses-three-more-participants

ACO Performance to Date

- 2015 independent evaluation:
- Pioneer ACO Model generated over $384 million in first two years = $300 per participating beneficiary per year

ACO Performance Results Demonstrate Savings to Medicare, Minimal Savings to Individual ACOs, Avalere, 9/18/14, http://avalere.com/news/aco-performance-results-demonstrate-savings-to-medicare-minimal-savings-to.
Fact sheets: Medicare ACOs continue to succeed in improving care, lowering cost growth, CMS, 9/16/2014, http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-09-16.html

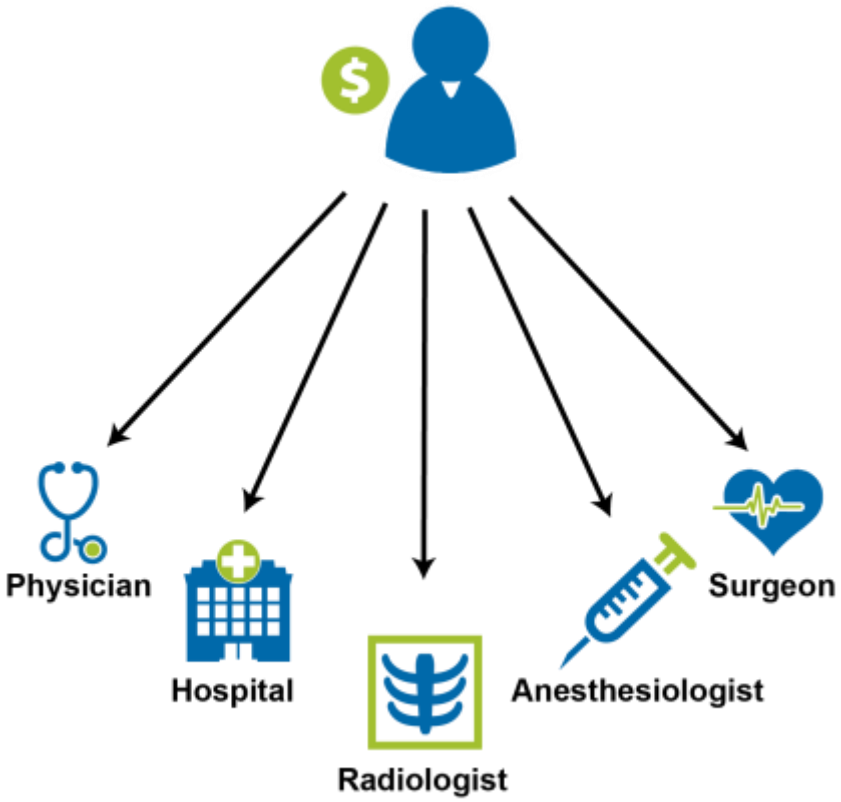
ACO Quality Results

ACO Type	Average Weighted Total Quality Score
Hospital System & Physician Group (Both)	76.99
Hospital System	75.44
Physician Group	71.82

Muhlestein, D. and Hall, C., ACO Quality Results: Good But Not Great, HealthAffairs Blog, 12/18/2014, http://healthaffairs.org/blog/2014/12/18/aco-quality-results-good-but-not-great/

Bundled Payments for Care Improvement

- Offering providers a single, bundled payment for an episode of care makes them jointly accountable for the patient's care.
- It also allows providers to achieve savings based on effectively managing resources.



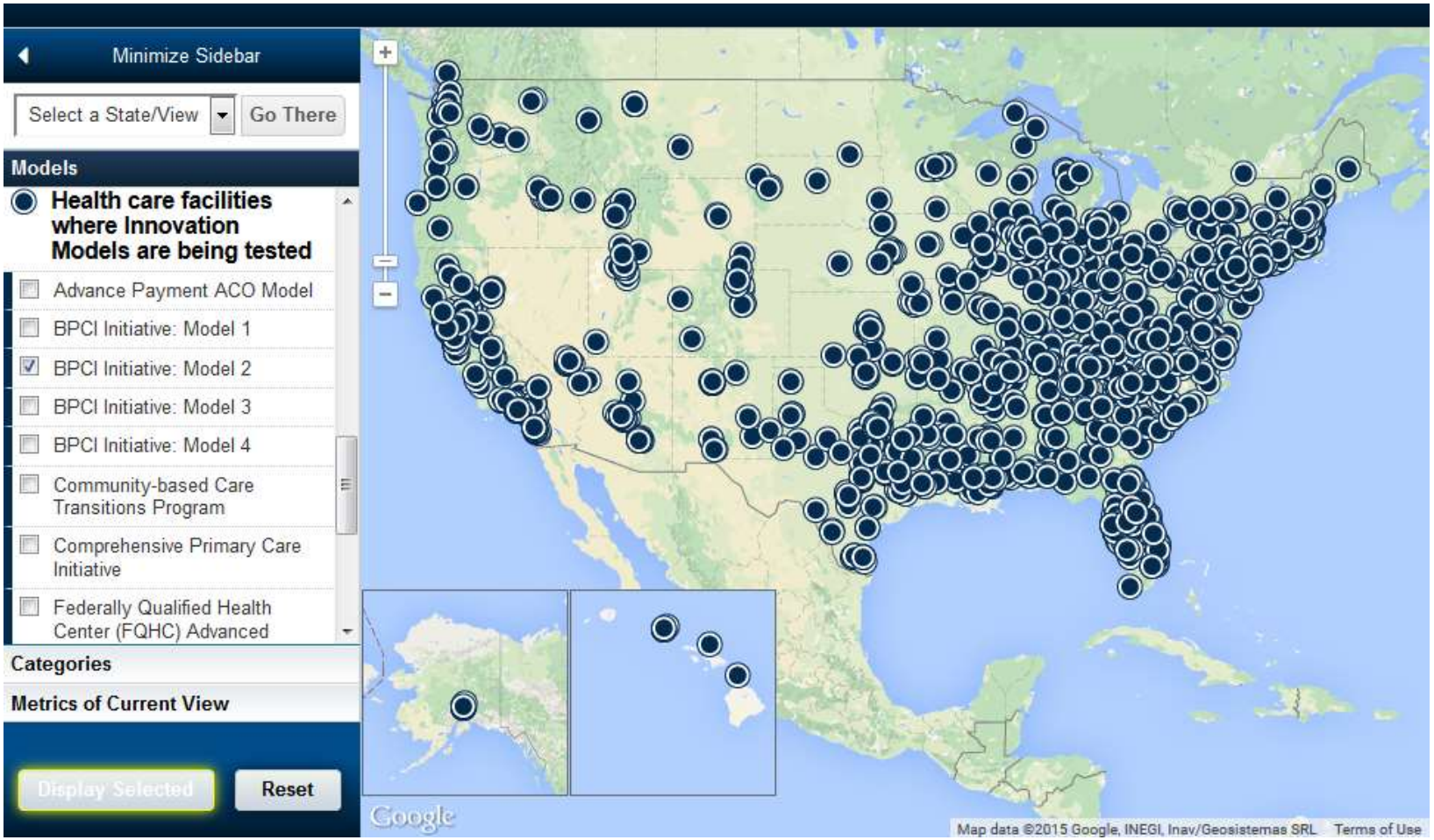
Four BPCI Models of Care

Model 1: Retrospective Acute Care Hospital Stay Only	• Hospital receives discounted IPPS payment amount • Physicians paid separately • They share savings arising from redesign efforts
Model 2: Retrospective Acute & Post Acute Care Episode	• Episode begins with inpatient admission and ends 30, 60, or 90 days after discharge • Spending reconciled against an established target price
Model 3: Retrospective Post Acute Care Only	• Episode begins with inpatient discharge and ends 30, 60, or 90 days after discharge • Spending reconciled against an established target price
Model 4: Prospective Acute Care Hospital Stay Only	• Hospital receives single bundled payment for all services, including readmissions for 30 days • Hospital pays physicians

BPCI

- 6,000 participating providers
  - 450 in 2013; 342 in 2014
- Phase 1 – most participants, non-risk bearing
- Phase 2 - only 4% of participants
- Model 3 – most popular, contains post acute
  - Orthopedic and cardiac bundles most popular
  - 50% of participants in Model 3 taking on all 48 conditions
  - 90% taking on 3+ bundles

BPCI 2



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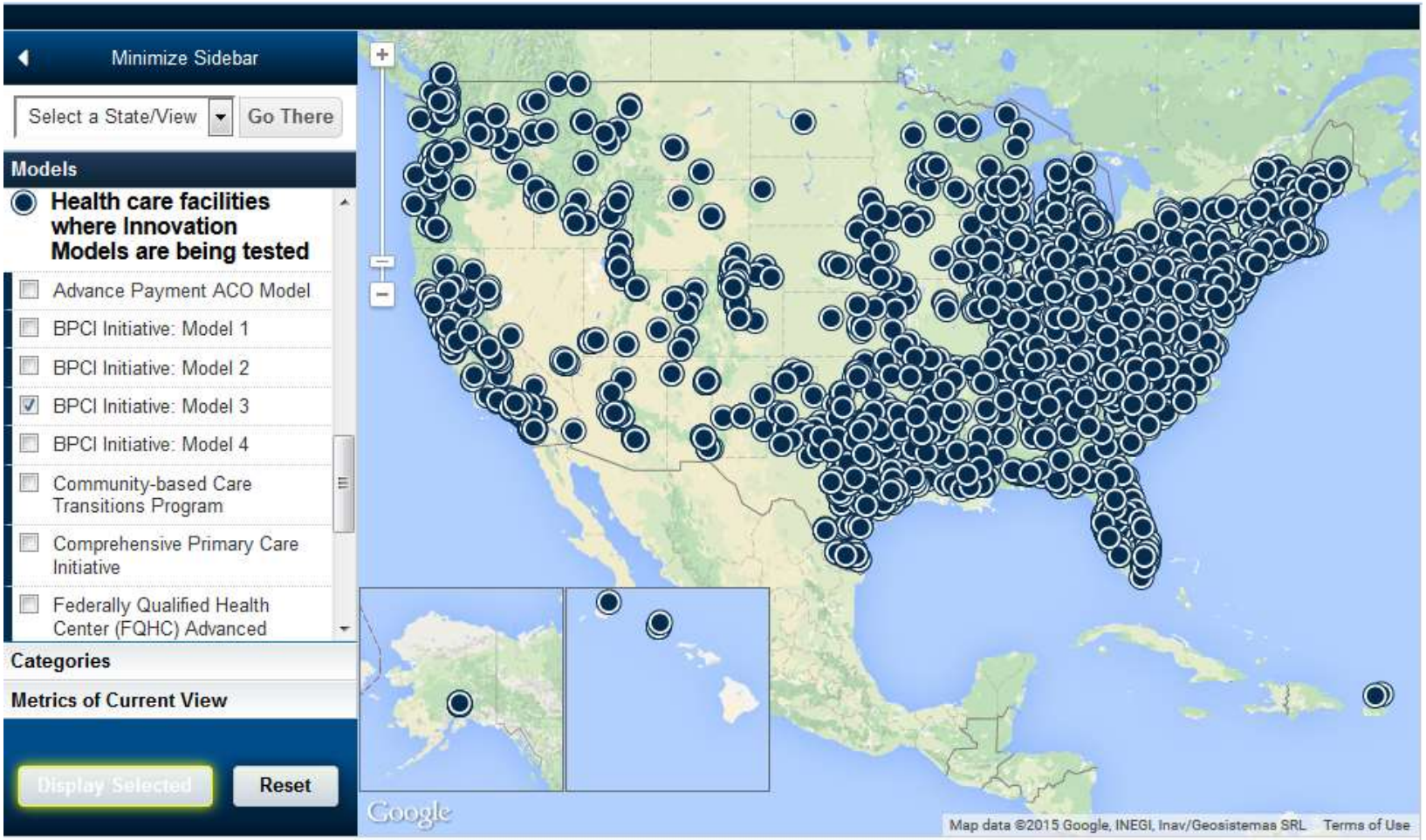
BPCI 3



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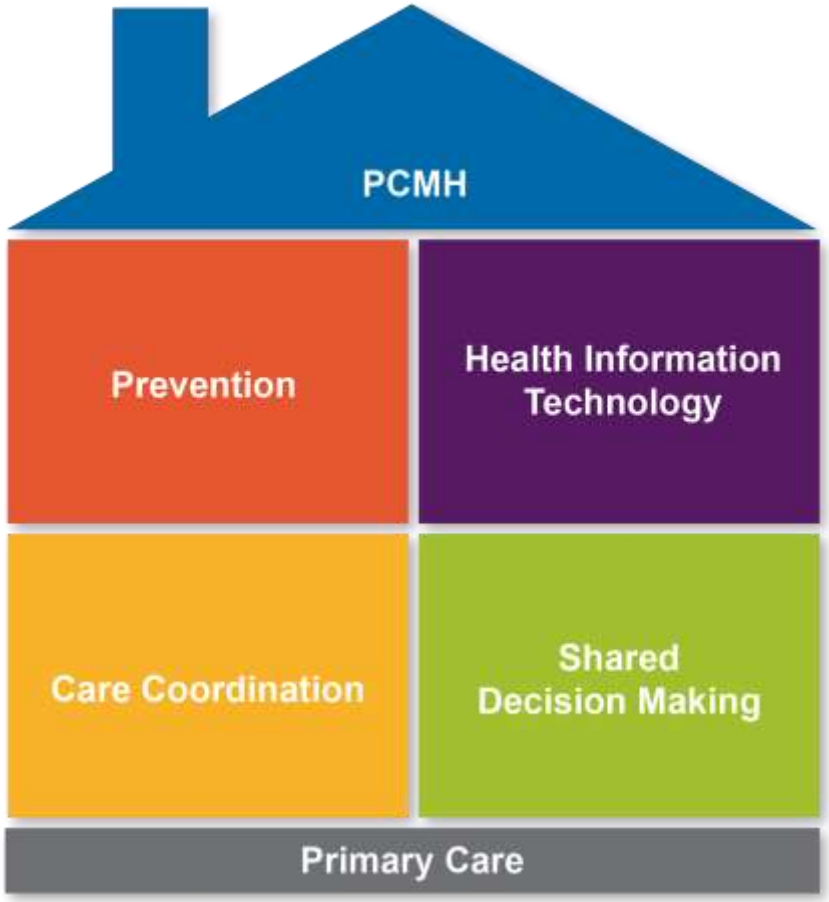
Evaluation of BPCI Models 2-4

- Model 2 Results
  - Preliminary results show that BPCI appears to have affected provider performance
  - Primarily hospitals are larger and urban with more affluent populations
    - Possibly indicates more resources to engage in care redesign
  - To date, hospitals applied bundled payments to more predictable hospitalizations that are more conducive to care redesign
- Model 3 and 4 – too early for results and samples too small

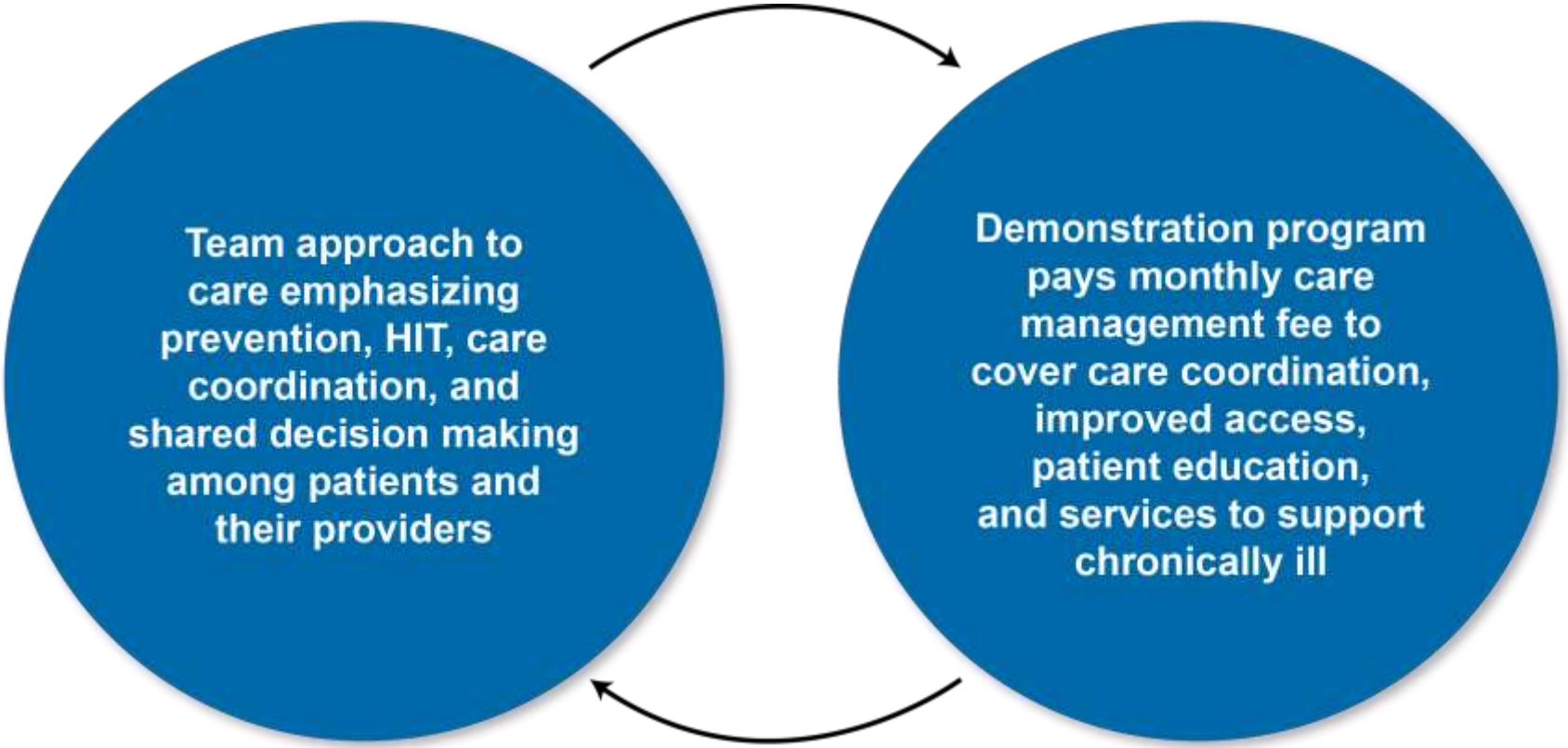
CMS Bundled Payments for Care Improvement (BPCI) Initiative Models 2-4: Year 1 Evaluation & Monitoring Annual Report, The Lewin Group, 2/2015, http://innovation.cms.gov/Files/reports/BPCI-EvalRpt1.pdf

Primary Care Transformation

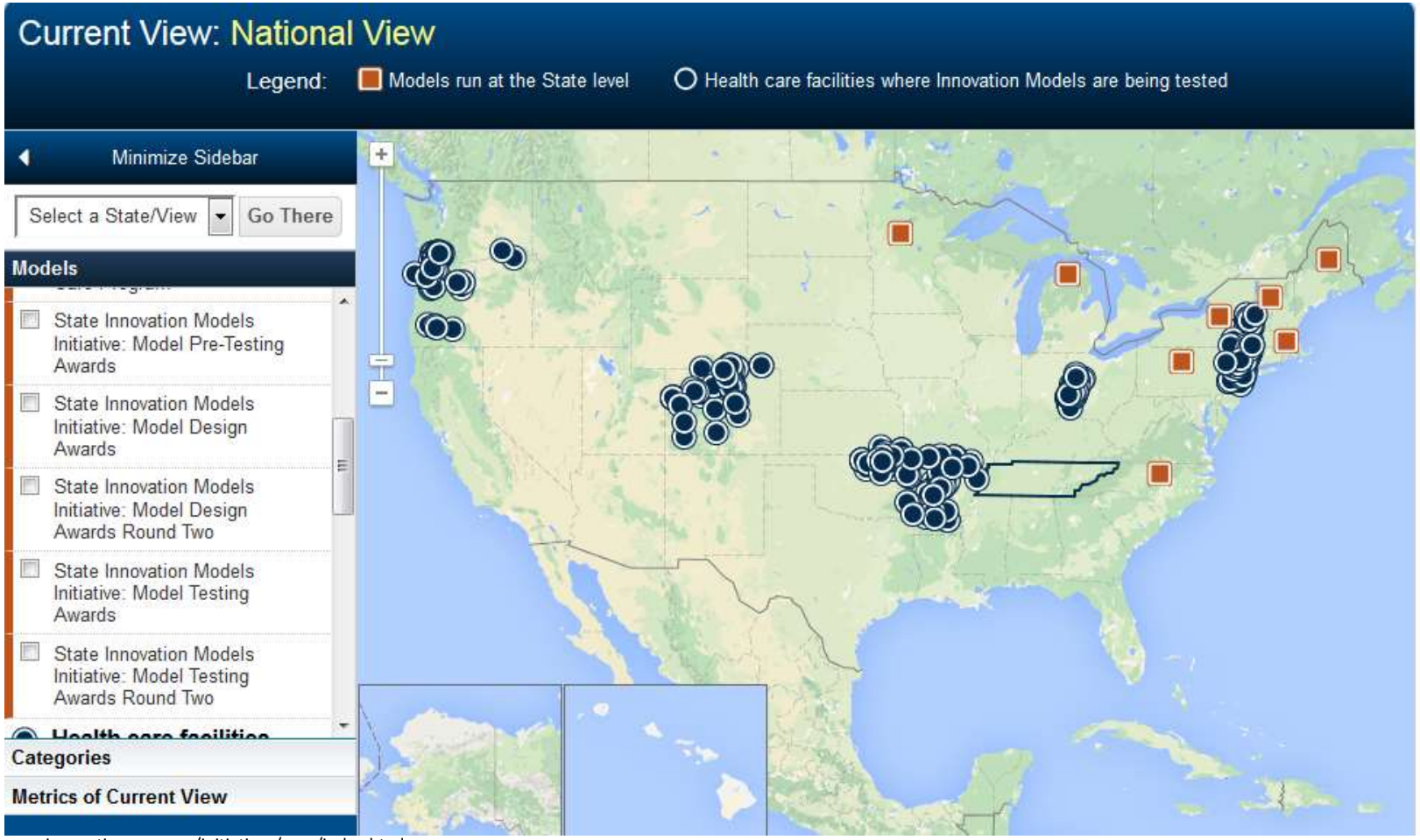
- Advanced primary care practices – “medical homes” – utilize a team-based approach, while emphasizing prevention, health information technology, care coordination and shared decision making among patients and their providers



Multi-Payer Advanced Primary Care Practice (MAPCP) or "Medical Homes"



CPCI in Blue/MPAPC in Red



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Comprehensive Primary Care Initiatives Results

- Mathematica Policy Research Evaluation, January 2015
- Overall for the 7 regions, CPCI resulted in some expenditure reduction
- For Oregon, Medicare expenditures and hospitalizations fell (but not statistically significant)
  - Large favorable effects on diabetes process-of-care measure

New Payment and Service Delivery Models

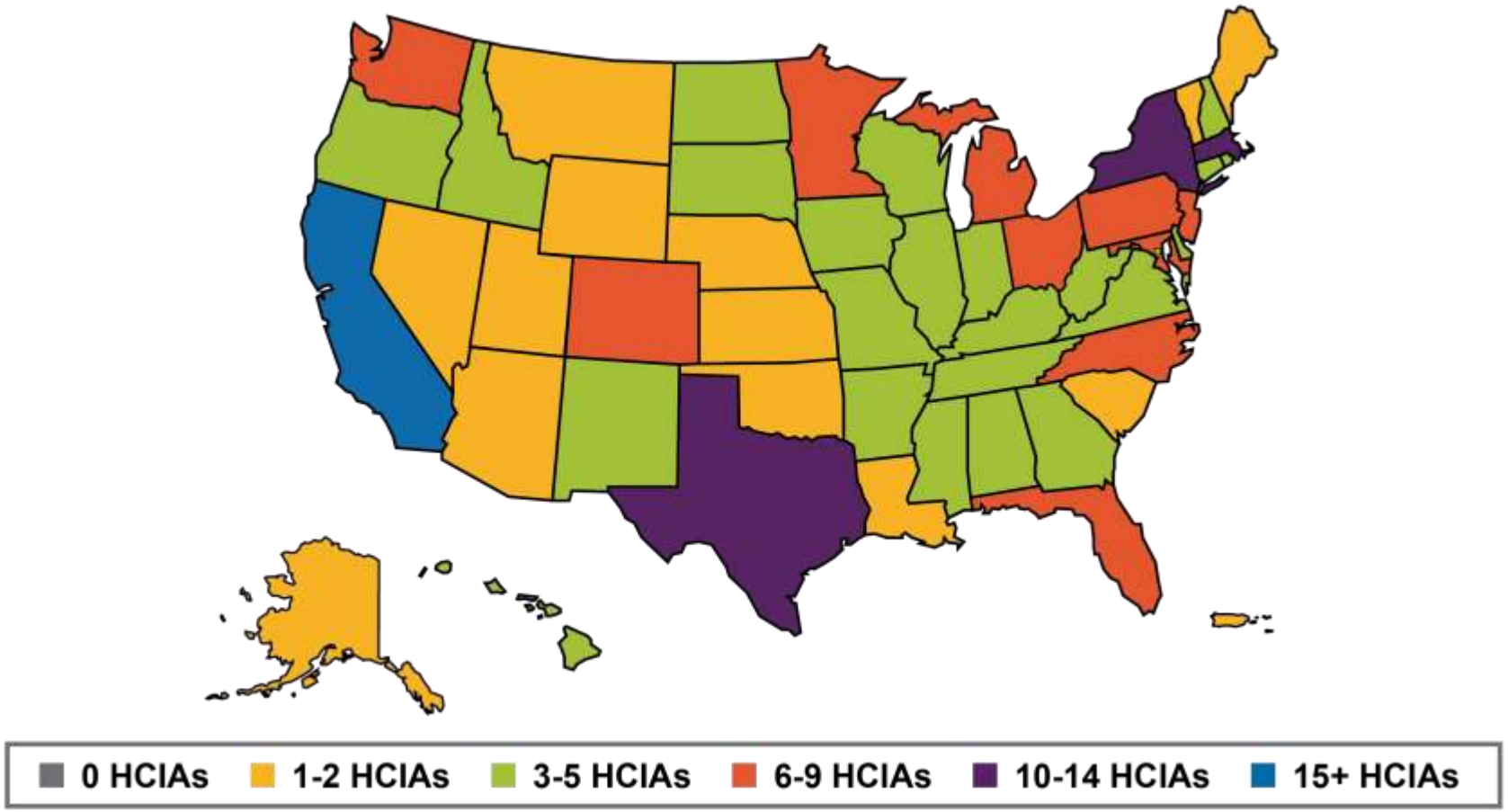
- Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models
  - Many innovations necessary to improve the health care system will come from local communities and health care leaders from across the country.
  - By partnering with these local and regional stakeholders, CMS can help accelerate the testing of models today that may be the next breakthrough tomorrow.

Health Care Innovation Awards

Round One: Seven General Areas

1. Complex/High Risk Patient Targeting
2. Disease Specific
3. Behavioral Health & Substance Abuse
4. Hospital Setting
5. Community Resource Planning, Prevention & Monitoring
6. Medication Management & Shared Decision Making
7. Primary Care Redesign

Health Care Innovation Awards Round One

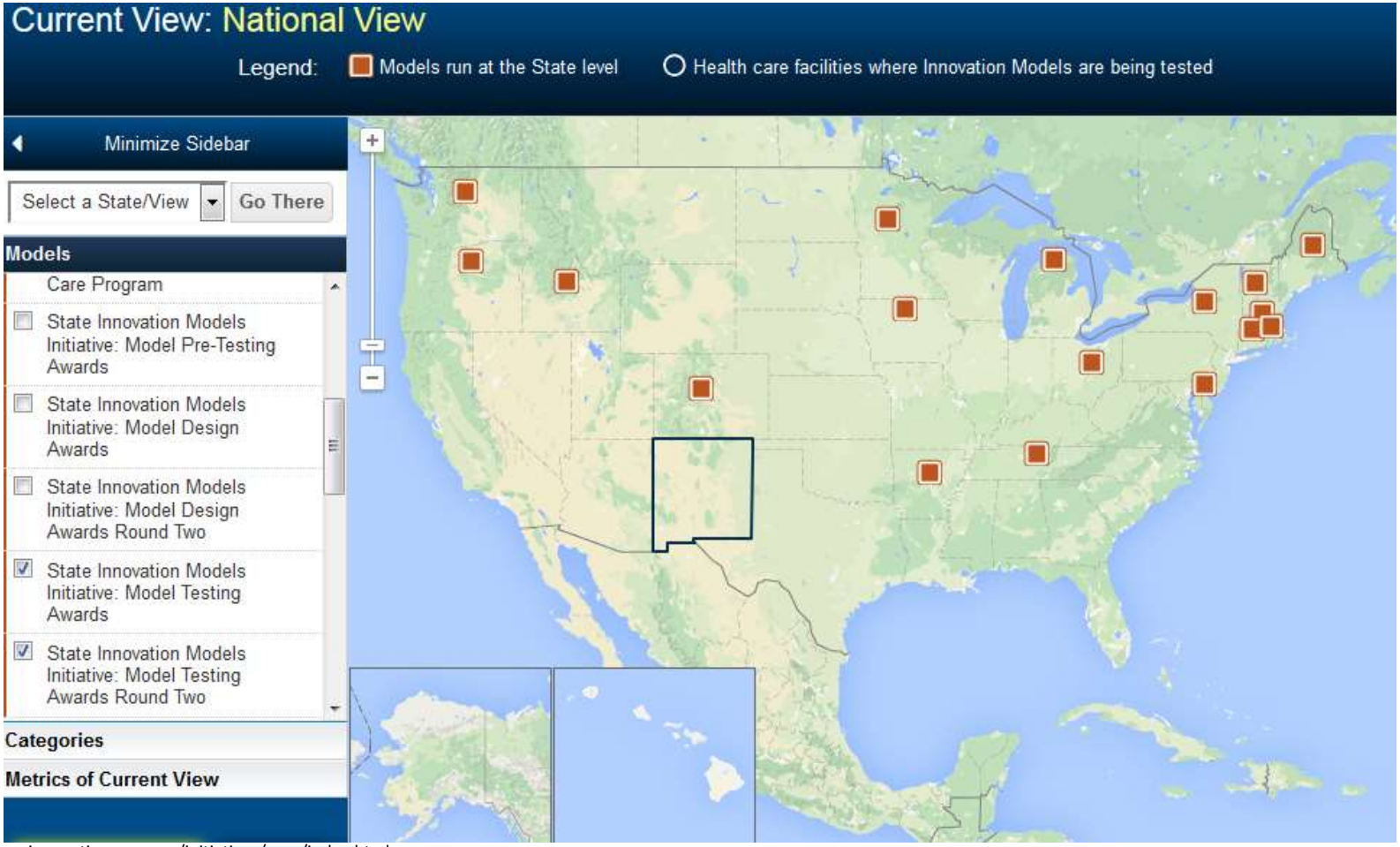


Centers for Medicare & Medicaid Services

State Innovation Models

- CMS views SIMs as a critical channel to accelerate health care transformation
- Overview –
  - Providing financial and technical support for development/testing of state-led, multi-payer health care payment and service delivery models
  - Round 1 - $300 million awarded to 25 states for
    - model design, model pre-test, model test
  - Round 2 - $660 million awarded to 32 awardees

SIM Test States



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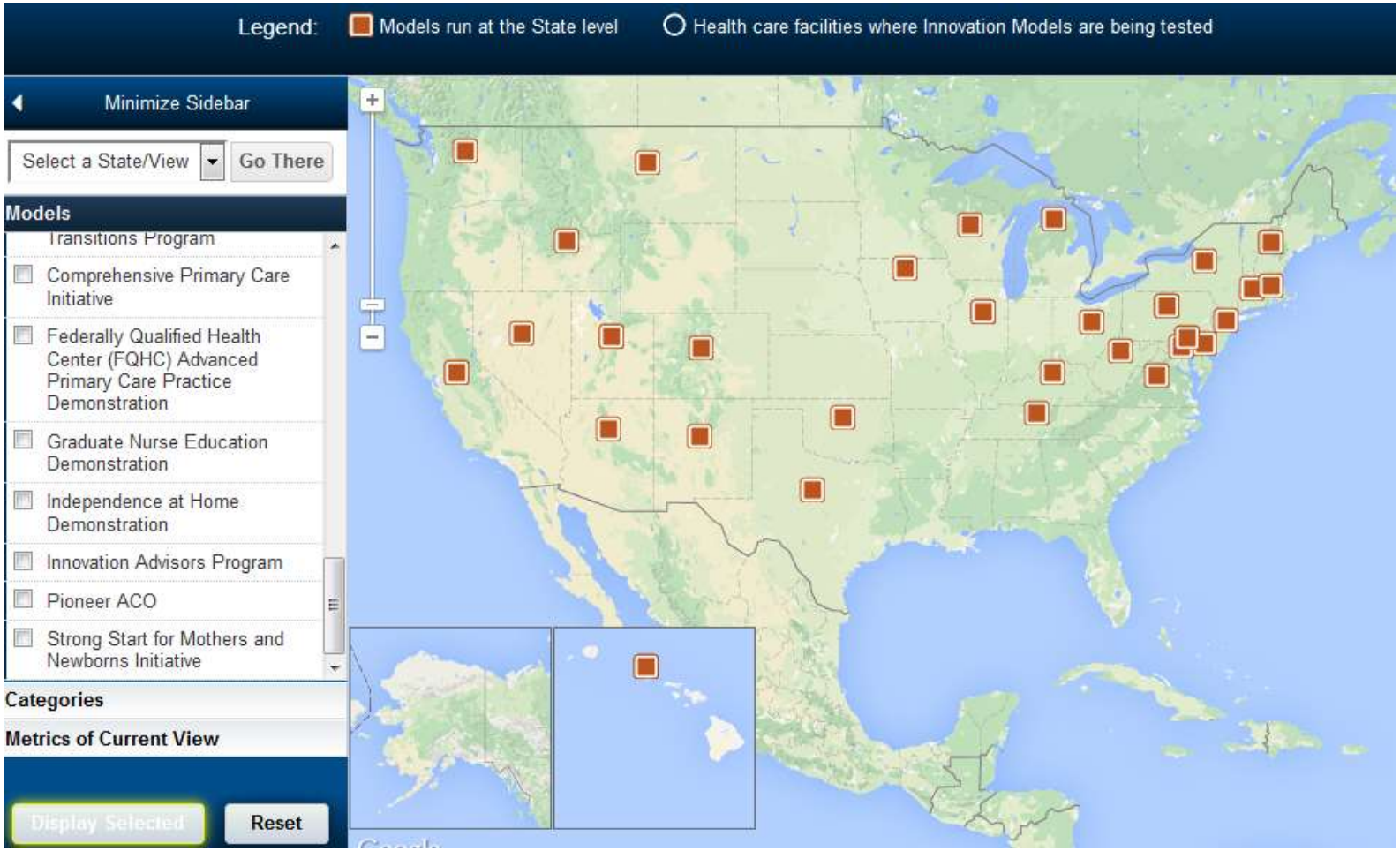
SIM Design States



innovation.cms.gov/initiatives/map/index.html

Idaho Round Two Model Test Awardee

- Idaho - $40 million
  - Patient-Centered Medical Home is cornerstone, including 75 virtual PCMHs
  - Statewide, multi-payer activity

IDAHO Department of Health and Welfare

Adoption of Best Practices

- Partnering with broad range of health care providers, federal agencies, professional societies, and other experts/stakeholders to test new models for disseminating evidence-based best practices and significantly increasing the speed of adoption.

Speed Best Practice Adoption

Projects	Status
Beneficiary Engagement Model Opportunities	Under Development
Community-based Care Transition Program	Ongoing
Health Care Payment Learning and Action Network	Announced
Innovation Advisors Program	Ongoing
Medicare Imaging Demonstration	No Longer Active
Million Hearts	Ongoing
Partnership for Patients	Ongoing

Medicare-Medicaid Enrollees

- Dual eligibles account for a disproportionate share of program expenditures.
- A fully integrated, person-centered system of care that ensures all of a beneficiary's needs are met – primary, acute, long-term care, prescription drug, behavioral, and social – could better serve this population in an improved, high-quality and cost-effective manner.

Medicaid and CHIP

Projects	Status
Medicaid Emergency Psychiatric	Ongoing
Medicaid Incentives for Prevention of Chronic Diseases	Ongoing
Medicaid Innovation Accelerator	Announced
Strong Start for Mothers and Newborns	Ongoing

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Value Based Payments

Benefit Updates – Changing Healthcare Delivery

Coordination of Services

Transitional Care Management (TCM)

- Complicated billing requirements
- Has not been widely adopted

Chronic Care Management (CCM)

- New as of January 1, 2015
- Regulations for use are less complex

Clinical Preventive Services

- Clinical Preventive Services that receive an “A” or “B” recommendation are to be provided without co-payment to beneficiaries.
- While providers are aware of these services, there appears to be a broad underutilization of these “free-to-the-beneficiary” services.

Preventive and Clinical Screening Services

- Abdominal aortic aneurysm screenings
- Bone mass measurements
- Cardiovascular disease screenings
- Cervical & vaginal cancer screenings
- Colorectal cancer screening
- Depression screenings
- Flu shots
- Glaucoma tests
- Hepatitis B shots
- HIV screenings
- Mammograms
- Pneumococcal shots
- Prostate cancer screenings
- Sexually transmitted infections screenings & counseling

Counseling Services

- Related to preventive services, counseling services are designed to educate beneficiaries on skills and tools to modify their behavior with evidence that changes in behavior can improve health status.
  - One-time “Welcome to Medicare” preventive visit
  - Yearly “Wellness” visit
  - Alcohol misuse screening & counseling
  - Cardiovascular disease (behavioral therapy)
  - Diabetes self-management training
  - Obesity screenings & counseling
  - Tobacco use cessation counseling
  - Nutrition therapy services

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Payment Incentives/Penalties

Quality Initiatives

Hospital Value Based Purchasing (VBP)	• Long-standing program in inpatient hospital setting • Participants paid for quality of care, not quantity of care • 1.5% withhold in FY15 increasing to 2% in FY17
Physician Quality Reporting System (PQRS)	• Eligible professionals avoid penalties by reporting quality measures • 1.5% to 2% penalty
Readmission Reduction Program	• Penalties for higher than expected readmissions • Up to 3% of inpatient revenue penalty • ¾ of hospitals received penalty ($428M in fines)

SGR Repeal – Creates MIPS

- Sun-setting of separate quality and incentive reporting and value-based payments.
- After 2019, Merit-Based Incentive Payment System (MIPS)

Other Quality Initiatives

Meaningful Use	• Financial incentive for meaningful use of certified EHR technology to improve patient care • Penalty of 1% begins this year if not MU certified
Hospital Compare	• Part of hospital quality initiative • Intent to improve hospital's quality of care by distributing objective, easy to understand data on hospital performance, and quality information from the consumer perspective
Nursing Home Compare	• Allows consumers to compare information about nursing homes (includes 15,000 NHs nationwide)

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For More Information

Sandeep Wadhwa, MD, MBA
CMO and SVP
Care & Delivery Management
sandeep.wadhwa@noridian.com
701-277-6596 (work)
720-579-1118 (mobile)